SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Filing at a Glance

Company: CMG Surety LLC

Product Name: Life Settlements	SERFF Tr Num: CMGS-126585722	State: Arkansas
TOI: VS01 Viatical Settlements	SERFF Status: Closed-Approved-Closed	State Tr Num: 45423
Sub-TOI: VS01.000 Viatical Settlements	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Ruth O'Brien	Disposition Date: 04/22/2010
	Date Submitted: 04/15/2010	Disposition Status: Approved-Closed
Implementation Date Requested: 04/15/2010		Implementation Date:

State Filing Description:

General Information

Project Name: Arkansas Application for Life Settlement Contract	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 09/21/2007
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/22/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/22/2010
Deemer Date:	Created By: Ruth O'Brien
Submitted By: Ruth O'Brien	Corresponding Filing Tracking Number:

Filing Description:

We have revised our "Application for Life Settlement Contract" form and are submitting for your review and approval.

Company and Contact

Filing Contact Information

Ruth O'Brien,	ruth@cmgsurety.com
1016 Collier Center Way	239-597-0128 [Phone]
Suite 100	239-597-1977 [FAX]
Naples, FL 34110	

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Filing Company Information

CMG Surety LLC	CoCode:	State of Domicile: Florida
1016 Collier Center Way	Group Code:	Company Type: Viatical Settlement Provider
Suite 100	Group Name:	State ID Number: 321492
Naples, FL 34110	FEIN Number: 74-3035738	
(239) 597-0128 ext. [Phone]		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
CMG Surety LLC	$0.00	04/15/2010	
CMG Surety LLC	$50.00	04/21/2010	35856673

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/22/2010	04/22/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	04/16/2010	04/16/2010	Ruth O'Brien	04/21/2010	04/21/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Cover Letter	Note To Reviewer	Ruth O'Brien	04/15/2010	04/15/2010

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Disposition

Disposition Date: 04/22/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Consent to Release Medical Records		Yes
Supporting Document	Escrow Agreement		No
Supporting Document	Physician Statement		No
Supporting Document	Power of Attorney		No
Form	Application for Life Settlement Contract-Redlined		Yes
Form	Application for Life Settlement Contract-Clean		Yes

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	04/16/2010
Submitted Date	04/16/2010
Respond By Date	05/17/2010

Dear Ruth O'Brien,

This will acknowledge receipt of the captioned filing.

Objection 1
No Objections
Comment: The filing fee was not included under EFT on this submission. Please refer to Arkansas Rule and Regulation 57, which was revised effective January 1, 2010, the filing fee is $50.00 per form. We will hold your filing in a pending status until the fee is received.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	04/21/2010
Submitted Date	04/21/2010

Dear Linda Bird,

Comments:

Response 1

Comments: Thank you for your note. We had trouble with our EFT and that was fixed today. The required $50 filing fee was submitted and processed. Please let me know if you need anything else. Thank you very much. -Ruth O'Brien, CMG Surety LLC

Related Objection 1

Comment:
The filing fee was not included under EFT on this submission. Please refer to Arkansas Rule and Regulation 57, which was revised effective January 1, 2010, the filing fee is $50.00 per form. We will hold your filing in a pending status until the fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Ruth O'Brien

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Note To Reviewer

Created By:
Ruth O'Brien on 04/15/2010 08:09 AM
Last Edited By:
Linda Bird
Submitted On:
04/16/2010 08:49 AM
Subject:
Cover Letter
Comments:
Attached please find our cover letter that accompanies the "Application for Life Settlement Contract" form being submitted via this filing for review and approval. We have made recent changes to this form which we are requesting approval for. Thank you.

CMG SURETY LLC

A FLORIDA LICENSED VIATICAL SETTLEMENT PROVIDER

1016 Collier Center Way, Suite 100 ♦ Naples, Florida 34110
Phone: 239-597-0128 ♦ Fax: 239-597-1977 ♦ *email: info@cmgsurety.com*

April 14, 2010

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: CMG Surety LLC – Viatical Settlement Provider
Revised "Application for Life Settlement Contract"
Submitted Via SERFF

To Whom It May Concern:

We have made some changes to our "Application for Life Settlement Contract" form and are submitting to you via SERFF for your approval. Please note that the changes being requested are in a "red-lined" format, so you can see what was changed from the previously-approved application form on file with your office. We have also included a "clean" copy of the application with these changes.

We look forward to hearing from you regarding our request for approval of these changes. Please feel free to contact me with any questions.

Sincerely,

R. Laken Mitchell
President
CMG Surety LLC

RLM:ro

Enclosure

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-APP	Policy/Contract/Fraternal Certificate	Application for Life Settlement Contract-Redlined	Initial			Arkansas Application for Life Settlement REVISED 4-1-10-Redlined.pdf
	L-APP	Policy/Contract/Fraternal Certificate	Application for Life Settlement Contract-Clean	Initial			Arkansas Application for Life Settlement REVISED 4-1-10-Clean.pdf

CMG Surety LLC
1016 Collier Center Way, Suite 100, Naples, Florida 34110
(239) 597-0128

APPLICATION FOR LIFE SETTLEMENT CONTRACT

Policy Owner Information

Full Name of Owner of Policy _____

Social Security # or EIN _____

Address _____

City _____ State _____ Zip _____

Home Phone (if individual) _____ Work Phone _____

May we contact you at work? Y/N Marital Status _____ Sex _____

Birthdate or Date of Formation _____

_____

Have you declared bankruptcy? Yes _____ No _____ (If yes, enclose a copy of the discharge)

If legal entity, type of entity _____

If legal entity, state of formation _____

If legal entity, names and titles of trustees, authorized officers, etc. _____

_____

_____

_____

Insured Information

Full Name of Insured _____

Social Security # or EIN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ May we contact you at work? Y/N

Birthdate _____ Marital Status _____ Sex _____

Please list the names and ages of all dependents _____

_____

Are you a defendant in any suits or legal actions? _____ If yes, describe _____

_____

Have you declared bankruptcy? Yes _____ No _____ (If yes, enclose a copy of the discharge)

Please list your present or last place of employment _____

Mailing Address _____

Phone Number _____

Date of Hire _____ Date Employment Ended _____

Reason for Leaving _____

Are you on disability? _____

Life Insurance Information

Name of Life Insurance Company _____

Coverage/Face Amount _____ Issue Date _____

Policy Type: Individual _____ Group _____ Other _____ Has policy ever lapsed?

Is this policy converted from a group policy? Yes ___ No ___ Date of Conversion _____

Beneficiary Information

Please list beneficiaries of the Policy:

_____

_____

_____

AUTHORIZATION TO RELEASE POLICY INFORMATION

I hereby authorize _____, the issuer of that certain policy number_____, Owned by_____, and insuring the life of _____, to release to CMG Surety LLC, or its authorized representative, any information, forms, riders, amendments or a true copy concerning this Policy. This authorization is for the maximum period allowed by state law. A photocopy or facsimile of this authorization shall be as valid as the original and I may request a copy of this information.

I acknowledge receipt of the Notice of Disclosure of Information

_____ _____

Signature of Policy Owner Date Full Name of Policy Owner (Type or Print)

STATE OF _____

COUNTY OF _____

On this day, before me, the undersigned, personally appeared _____, is personally known to me, or proved to me with satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person or the entity upon behalf of which person acted, executed the instrument.

Witness my hand and official seal on the _____ day of _____, 20_____

My Commission Expires:

_____ _____

(Seal) SIGNATURE OF NOTARY PUBLIC

_____ Personally Known to me
_____ Produced Identification – Type _____

MEDICAL INFORMATION

What is the medical term for your illness?

_____

Please provide us with information concerning your current medical condition regarding treatment, medications, etc. _____

_____

_____

Have you been diagnosed as terminally ill? _____ Diagnosis date _____

If HIV/AIDS: T-cell count _____ Viral load _____

Opportunistic Infections _____

_____

_____

Please provide the name of your physician and/or hospital so that we may contact them to obtain your medical records. For additional health care providers, please use additional sheet.

PHYSICIAN

Name _____

Address _____

City, State, Zip _____

Phone Number _____ Fax # _____

HOSPITAL

Name _____

Address _____

City, State, Zip _____

Phone Number _____ Fax # _____

Additional comments that may assist in determining your eligibility _____

_____

_____

_____

_____

_____

TERMS AND CONDITIONS

A. The Applicant(s) warrant and represent that all information contained herein is true and correct to the best of his/her knowledge.

B. The Applicant(s) hereby authorize CMG Surety LLC or its authorized representative, to obtain a credit report on the Applicant(s).

C. The Insured consents to be examined by CMG Surety LLC at its expense and to the re-disclosure of any medical records. The Applicant(s) consent to the release to CMG Surety LLC any documents needed to allow CMG Surety LLC to conduct such examinations or acquire such information.

D. The Applicant(s) herein includes a photocopy of his/her driver's license or a picture identification and swears and warrants that he/she is in fact that person so identified.

Pursuant to certain state laws governing life settlement contracts, the following information and advice is to be disclosed to you. **Please initial each item,** sign where indicated and return to us in the envelope provided.

In connection with the sale of the policy from the policy Owner, CMG Surety LLC, hereby discloses certain information to the Policy Owner (anyone selling or assigning the rights to a life insurance policy's death benefit to a third party) regarding the transaction:

_____ I have full and complete mental capacity to fully understand the nature and effect of the transaction, namely the settlement (selling or assigning the rights to a life insurance policy's death benefits to a third party) of the life insurance policy.

_____ I understand that there are possible alternatives to life settlement contracts, including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.

_____ I have full and complete understanding of the benefits of the policy which I am selling and the insurance company does not offer a living benefits or accelerated benefits program and/or that I do not qualify for any such accelerated benefits at this time, or that the surrender of the policy to such a program, if available, is less satisfactory as to form or surrender value than that being contemplated via CMG Surety LLC.

_____ I have a full and complete understanding of the consequences of the transaction herein contemplated, including any income tax effects and the effects any sale may have on any state or federal means based benefits, aid, assistance or benefits from any and all federal, state, or other relevant assistance programs which I am now receiving or may be otherwise entitled to receive in the future. I acknowledge that I have been encouraged to seek financial and/or legal advice from competent local professionals if I have any questions on such effects.

_____ I understand that notwithstanding any other provisions of any instrument utilized in the transaction, I retain an absolute right to rescind any transaction, verbally or in writing, within fifteen (15) calendar days after the receipt of the life settlement proceeds. This right cannot be waived by either the Owner or CMG Surety LLC.

_____ I understand that the proceeds that I will receive from this transaction may be subject to the claims of creditors. I also understand that receipt of these proceeds could affect my eligibility for Medicaid or other government benefits or entitlements, and that I have been encouraged to seek advice from the appropriate agencies.

_____ I understand that the independent third-party Escrow Agent that will be handling this transaction is ~~Mills, Potoczak & Company, 27600 Chagrin Boulevard, Suite 200, Cleveland, Ohio 44122-4464, 216-464-7481~~ _____.

I also understand that I may inspect or receive copies of the Escrow Agreement or related documents upon my request.

_____ I understand that some or all of the proceeds of this transaction may be taxable under federal income tax law and I have been advised to seek assistance from a professional tax advisor.

_____ I understand and accept that CMG Surety LLC may assign, sell or otherwise transfer its interest in the policy to a third party and that such third party would then control the policy, and the personal data of owner and insured.

_____ I understand that funds for the purchase of a policy will be sent to me within three business days after the escrow agent has been notified that ownership of the policy has been transferred to CMG or its assigns.

_____ I understand that entering into a life settlement contract may cause other rights of benefits, including conversion rights and waiver of premium benefits that may exist under a policy to be forfeited by me and assistance should be sought from a financial advisor

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

Signature of Insured (if different than Owner)	Date	Full Name of Insured (Type or Print) (if different than Owner)	
Signature of Owner	Date	Full Name of Owner (Type or Print)	
Signature of Witness	Date	Full Name of Witness (Type or Print)	

CMG Surety LLC
1016 Collier Center Way, Suite 100, Naples, Florida 34110
(239) 597-0128

AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

Patient's (insured's) name:_____

Date of Birth:_____ Social Security #:_____

The undersigned insured (hereafter referred to as "I"), hereby authorize the disclosure of my protected health information (PHI) as follows:

1. **Classes of Persons Authorized to Disclose My PHI:** I authorize any physician, medical practitioner, physician practice group, hospital or medical related facility, health care provider, or other institution or person(s) (each an "Authorized Discloser") having any records, charts, X-rays, laboratory work, or similar information regarding my health, to release and disclose such PHI as provided in this authorization. I authorize each Authorized Discloser to rely upon a photographic or facsimile copy or other reproduction of this authorization.

2. **Person Authorized to Receive My PHI:** I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to CMG Surety LLC (including its officers, employees, agents, independent contractors, and authorized representatives, and service providers, including, but not limited to, ~~Life Settlement Providers LLC,~~ EMSI, American Viatical Services, Inc., ~~and~~ 21st Services, Inc., a financial institution and any subsequent purchaser of the policy under which I am insured) and to any other entity which is required or is compelled to receive such PHI to complete a settlement transaction, to service the policy and the related data, or in order to sell a Life Settlement Contract (collectively, the "Authorized Recipient"). I understand that my PHI may be secured by a third party provider and may be electronically transmitted to the Authorized Recipient.

3. **Description of PHI Authorization for Disclosure and the Purposes for such Disclosure:** This authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including, but not limited to, the following:

   * Physician's/nurse's notes;
   * Examination summaries;
   * Reports and orders;
   * Medication and prescription drug records;
   * Radiology, pathology and other laboratory and test reports; and
   * Other information/documentation included in a medical file.

   This authorization and all disclosure of my PHI made pursuant to this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible sale of any or all life insurance policies under which my life is insured; and (2) to verify, track, and monitor my health and medical status and condition in connection with any and all life insurance policies under which my life is insured that are sold.

4. **Expiration of Authorization:** This authorization shall remain valid and shall expire on the date of my death.

5. **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided that any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation.

I acknowledge and understand that this authorization is not a consent or an authorization requested by a health care provider, healthcare clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that as a result of this authorization any of my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be re-disclosed by the Authorized Recipient to a subsequent purchaser or servicer of the policy, and that my PHI that is disclosed to the Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely, voluntarily and unilaterally as of the date written below. I further certify that I understand this authorization written in plain language and that I have retained a copy of this signed authorization for future reference.

_____ _____

Signature of Patient (Insured) Date

_____

Printed Name of Patient (Insured)

CMG Surety LLC
1016 Collier Center Way, Suite 100, Naples, Florida 34110
(239) 597-0128

APPLICATION FOR LIFE SETTLEMENT CONTRACT

Policy Owner Information

Full Name of Owner of Policy _____

Social Security # or EIN _____

Address _____

City _____ State _____ Zip _____

Home Phone (if individual) _____ Work Phone _____

May we contact you at work? Y/N Marital Status _____ Sex _____

Birthdate or Date of Formation _____

_____

Have you declared bankruptcy? Yes _____ No _____ (If yes, enclose a copy of the discharge)

If legal entity, type of entity _____

If legal entity, state of formation _____

If legal entity, names and titles of trustees, authorized officers, etc. _____

_____

_____

_____

Insured Information

Full Name of Insured _____

Social Security # or EIN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ May we contact you at work? Y/N

Birthdate _____ Marital Status _____ Sex _____

Please list the names and ages of all dependents _____

_____

Are you a defendant in any suits or legal actions? _____ If yes, describe _____

_____

Have you declared bankruptcy? Yes _____ No _____ (If yes, enclose a copy of the discharge)

Please list your present or last place of employment _____

Mailing Address _____

Phone Number _____

Date of Hire _____ Date Employment Ended _____

Reason for Leaving _____

Are you on disability? _____

Life Insurance Information

Name of Life Insurance Company _____

Coverage/Face Amount _____ Issue Date _____

Policy Type: Individual _____ Group _____ Other _____ Has policy ever lapsed?

Is this policy converted from a group policy? Yes ___ No ___ Date of Conversion _____

Beneficiary Information

Please list beneficiaries of the Policy:

_____

_____

_____

AUTHORIZATION TO RELEASE POLICY INFORMATION

I hereby authorize _____, the issuer of that certain policy number_____, Owned by_____, and insuring the life of _____, to release to CMG Surety LLC, or its authorized representative, any information, forms, riders, amendments or a true copy concerning this Policy. This authorization is for the maximum period allowed by state law. A photocopy or facsimile of this authorization shall be as valid as the original and I may request a copy of this information.

I acknowledge receipt of the Notice of Disclosure of Information

_____ _____

Signature of Policy Owner Date Full Name of Policy Owner (Type or Print)

STATE OF _____

COUNTY OF _____

On this day, before me, the undersigned, personally appeared _____, is personally known to me, or proved to me with satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person or the entity upon behalf of which person acted, executed the instrument.

Witness my hand and official seal on the _____ day of _____, 20_____

My Commission Expires:

_____ _____

(Seal) SIGNATURE OF NOTARY PUBLIC

_____ Personally Known to me
_____ Produced Identification – Type _____

MEDICAL INFORMATION

What is the medical term for your illness?

_____

Please provide us with information concerning your current medical condition regarding treatment, medications, etc. _____

_____

_____

Have you been diagnosed as terminally ill? _____ Diagnosis date _____

If HIV/AIDS: T-cell count _____ Viral load _____

Opportunistic Infections _____

_____

_____

Please provide the name of your physician and/or hospital so that we may contact them to obtain your medical records. For additional health care providers, please use additional sheet.

PHYSICIAN

Name _____

Address _____

City, State, Zip _____

Phone Number _____ Fax # _____

HOSPITAL

Name _____

Address _____

City, State, Zip _____

Phone Number _____ Fax # _____

Additional comments that may assist in determining your eligibility _____

_____

_____

_____

_____

_____

TERMS AND CONDITIONS

A. The Applicant(s) warrant and represent that all information contained herein is true and correct to the best of his/her knowledge.

B. The Applicant(s) hereby authorize CMG Surety LLC or its authorized representative, to obtain a credit report on the Applicant(s).

C. The Insured consents to be examined by CMG Surety LLC at its expense and to the re-disclosure of any medical records. The Applicant(s) consent to the release to CMG Surety LLC any documents needed to allow CMG Surety LLC to conduct such examinations or acquire such information.

D. The Applicant(s) herein includes a photocopy of his/her driver's license or a picture identification and swears and warrants that he/she is in fact that person so identified.

Pursuant to certain state laws governing life settlement contracts, the following information and advice is to be disclosed to you. **Please initial each item,** sign where indicated and return to us in the envelope provided.

In connection with the sale of the policy from the policy Owner, CMG Surety LLC, hereby discloses certain information to the Policy Owner (anyone selling or assigning the rights to a life insurance policy's death benefit to a third party) regarding the transaction:

_____ I have full and complete mental capacity to fully understand the nature and effect of the transaction, namely the settlement (selling or assigning the rights to a life insurance policy's death benefits to a third party) of the life insurance policy.

_____ I understand that there are possible alternatives to life settlement contracts, including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.

_____ I have full and complete understanding of the benefits of the policy which I am selling and the insurance company does not offer a living benefits or accelerated benefits program and/or that I do not qualify for any such accelerated benefits at this time, or that the surrender of the policy to such a program, if available, is less satisfactory as to form or surrender value than that being contemplated via CMG Surety LLC.

_____ I have a full and complete understanding of the consequences of the transaction herein contemplated, including any income tax effects and the effects any sale may have on any state or federal means based benefits, aid, assistance or benefits from any and all federal, state, or other relevant assistance programs which I am now receiving or may be otherwise entitled to receive in the future. I acknowledge that I have been encouraged to seek financial and/or legal advice from competent local professionals if I have any questions on such effects.

_____ I understand that notwithstanding any other provisions of any instrument utilized in the transaction, I retain an absolute right to rescind any transaction, verbally or in writing, within fifteen (15) calendar days after the receipt of the life settlement proceeds. This right cannot be waived by either the Owner or CMG Surety LLC.

_____ I understand that the proceeds that I will receive from this transaction may be subject to the claims of creditors. I also understand that receipt of these proceeds could affect my eligibility for Medicaid or other government benefits or entitlements, and that I have been encouraged to seek advice from the appropriate agencies.

_____ I understand that the independent third-party Escrow Agent that will be handling this transaction is _____.
I also understand that I may inspect or receive copies of the Escrow Agreement or related documents upon my request.

_____ I understand that some or all of the proceeds of this transaction may be taxable under federal income tax law and I have been advised to seek assistance from a professional tax advisor.

_____ I understand and accept that CMG Surety LLC may assign, sell or otherwise transfer its interest in the policy to a third party and that such third party would then control the policy, and the personal data of owner and insured.

_____ I understand that funds for the purchase of a policy will be sent to me within three business days after the escrow agent has been notified that ownership of the policy has been transferred to CMG or its assigns.

_____ I understand that entering into a life settlement contract may cause other rights of benefits, including conversion rights and waiver of premium benefits that may exist under a policy to be forfeited by me and assistance should be sought from a financial advisor

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

_____		_____	
Signature of Insured (if different than Owner)	Date	Full Name of Insured (Type or Print) (if different than Owner)	
_____		_____	
Signature of Owner	Date	Full Name of Owner (Type or Print)	
_____		_____	
Signature of Witness	Date	Full Name of Witness (Type or Print)	

CMG Surety LLC
1016 Collier Center Way, Suite 100, Naples, Florida 34110
(239) 597-0128

AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

Patient's (insured's) name:_____

Date of Birth:_____ Social Security #:_____

The undersigned insured (hereafter referred to as "I"), hereby authorize the disclosure of my protected health information (PHI) as follows:

1. **Classes of Persons Authorized to Disclose My PHI:** I authorize any physician, medical practitioner, physician practice group, hospital or medical related facility, health care provider, or other institution or person(s) (each an "Authorized Discloser") having any records, charts, X-rays, laboratory work, or similar information regarding my health, to release and disclose such PHI as provided in this authorization. I authorize each Authorized Discloser to rely upon a photographic or facsimile copy or other reproduction of this authorization.

2. **Person Authorized to Receive My PHI:** I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to CMG Surety LLC (including its officers, employees, agents, independent contractors, and authorized representatives, and service providers, including, but not limited to, EMSI, American Viatical Services, Inc., 21st Services, Inc., a financial institution and any subsequent purchaser of the policy under which I am insured) and to any other entity which is required or is compelled to receive such PHI to complete a settlement transaction, to service the policy and the related data, or in order to sell a Life Settlement Contract (collectively, the "Authorized Recipient"). I understand that my PHI may be secured by a third party provider and may be electronically transmitted to the Authorized Recipient.

3. **Description of PHI Authorization for Disclosure and the Purposes for such Disclosure:** This authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including, but not limited to, the following:

   * Physician's/nurse's notes;
   * Examination summaries;
   * Reports and orders;
   * Medication and prescription drug records;
   * Radiology, pathology and other laboratory and test reports; and
   * Other information/documentation included in a medical file.

   This authorization and all disclosure of my PHI made pursuant to this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible sale of any or all life insurance policies under which my life is insured; and (2) to verify, track, and monitor my health and medical status and condition in connection with any and all life insurance policies under which my life is insured that are sold.

4. **Expiration of Authorization:** This authorization shall remain valid and shall expire on the date of my death.

5. **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided that any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation.

I acknowledge and understand that this authorization is not a consent or an authorization requested by a health care provider, healthcare clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that as a result of this authorization any of my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be re-disclosed by the Authorized Recipient to a subsequent purchaser or servicer of the policy, and that my PHI that is disclosed to the Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely, voluntarily and unilaterally as of the date written below. I further certify that I understand this authorization written in plain language and that I have retained a copy of this signed authorization for future reference.

_____ _____

Signature of Patient (Insured) Date

_____

Printed Name of Patient (Insured)

SERFF Tracking Number:	*CMGS-126585722*	*State:*	*Arkansas*
Filing Company:	*CMG Surety LLC*	*State Tracking Number:*	*45423*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Life Settlements*		
Project Name/Number:	*Arkansas Application for Life Settlement Contract/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Consent to Release Medical Records

Comments:

Insureds consent to release of medical records is included in the "Application for Life Settlement Contract" as authorization to release policy information and authorization for disclosure of PHI.

Item Status: **Status Date:**

Bypassed - Item: Escrow Agreement

Bypass Reason: We are only submitting an Application for review and approval via this filing.

Comments:

Item Status: **Status Date:**

Bypassed - Item: Physician Statement

Bypass Reason: We are only submissing an Application for review and approval via this filing. The physical statement is included in the contract form which has already been approved by your office.

Comments:

Item Status: **Status Date:**

Bypassed - Item: Power of Attorney

Bypass Reason: We are only submitting an Application for review and approval via this filing. The power of attorney is included in the contract form which has already been approved by your office.

Comments: